VOL. 13, NO. 6 MARCH-APRIL, 1964

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The Center is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Department of Mental Health. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay if the patient is able to pay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the professional staff, educational films, individual consultations with staff members, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the medical director, one other physician, a psychiatric social worker, psychologist, chaplain and admitting officer, vocational rehabilitation counselor, activities director, and a full attendant staff.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment in response to written or telephone request to the Medical Director of the Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment. All appointments must be confirmed by mail and should preferably be made by the patient's physician or by other professional personnel in the patient's community, for example, alcoholism information center personnel.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history,

compiled by the patient's family physician. are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission if the patient is able.

4. Sign a letter-statement requesting voluntary admission at the time of admission.

It is especially important that patients applying for admission have a thorough medical examination and be in good physical condition at the time of their admission. The Center is not a hospital or a sobering up facility and patients desiring admission should have been sober for at least seventy-two hours and should not be exhibiting withdrawal symptoms. There are no facilities provided at the Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

Wednesday, Thursday and Friday during the morning and afternoon. Patients may have visitors after they've been at the Center for 2 weeks. Visiting hours are from 1:00-4:00 P.M. on Saturday and Sunday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA DEPARTMENT OF MENTAL HEALTH

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INVENTORY

VOLUME 13 NUMBER 6

MARCH-APRIL, 1964

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices 2100 Hillsboro St., Raleigh, North Carolina.

This journal is printed as a public information service. Persons desiring a place on the free mailing list must send in a written request, with the exception that *new* requests from *individuals* residing outside North Carolina can no longer be accepted. The views expressed in articles published in *Inventory* are those of the authors and not necessarily those of the NCARP. Manuscripts are invited with understanding that no fees can be paid.

Write: INVENTORY, P. O. Box 9494, Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912

A Year of Changes

BY NORMAN A. DESROSIERS, M.D.
MEDICAL DIRECTOR
ALCOHOLIC REHABILITATION CENTER
BUTNER, N. C.

1963 was a year of changes for alcoholic rehabilitation in North Carolina, according to a man who helped make them.

AS we stand at the threshold of a new year, those of us working in alcoholic rehabilitation are wont to reflect on events that took place in this field during the past year. We may begin our reflections by noting that 1963 was a year of changes, both at the state-wide level as well as at the North Carolina Alcoholic Rehabilitation Center and the state mental hospitals.

We have witnessed a change in the legal aspects of handling the alcoholic on a committed basis. The new law passed by the 1963 Legislature embodied realistic consideration of the alcoholic as an emotionally sick person by putting his admission on the same type legal commitment as that of the mental patient. This change recognized that the alcoholic can be indigent, and yet require treatment, by eliminating the so-called 30-day "alcoholic commitment" paper with its mandatory $75 fee. The four procedures for the admission of mental patients and alcoholics are: voluntary, involuntary, medical certification and emergency.

Before the change in law, alcoholics were admitted to only two of the state mental hospitals—Dorothea Dix and Cherry. Now, as a direct consequence of the change, bed space is available at all four hospitals. In all, some 300 beds are available to alcoholics in the state mental hospital system. Counting broadly on the turnover of each bed every 30 days, twelve times a year, it will now be possible to treat a total of 3,600 alcoholics a year. However, note that the *minimum* estimate for the number of alcoholics in North Carolina is 52,000 (the actual figure is probably closer to 100,000) and, on the basis of this comparison, two brief observations can be made. Inpatient treatment for alcoholics in North Carolina must be of practical necessity very limited and should be reserved for those patients who really require it. These figures also point to, in a rather dramatic fashion, the need for providing outpatient facilities in our developing mental health clinics to accommodate the treatment of additional alcoholics. Experience in other states has shown that outpatient clinics can successfully treat alcoholics as well as serve as a screening facility for inpatient referral. Indeed, such experience also indicates that a great many alcoholics can *best* be treated on an outpatient basis.

The new law on inebriate commitment has begun to show its effect on the admissions at the Center. With the exception of December, which always shows a slump in voluntary admissions due to the holidays, there was a rise in the daily population census beginning in September and October which ranged from the average daily population of 32 for the first

eight months to 44 in September and 51 in October. Though it remains to be seen, it is anticipated that this trend will continue during 1964.

Turning from the large scale statewide changes that have taken place, let us now review the changes that have been effected at the North Carolina Alcoholic Rehabilitation Center.

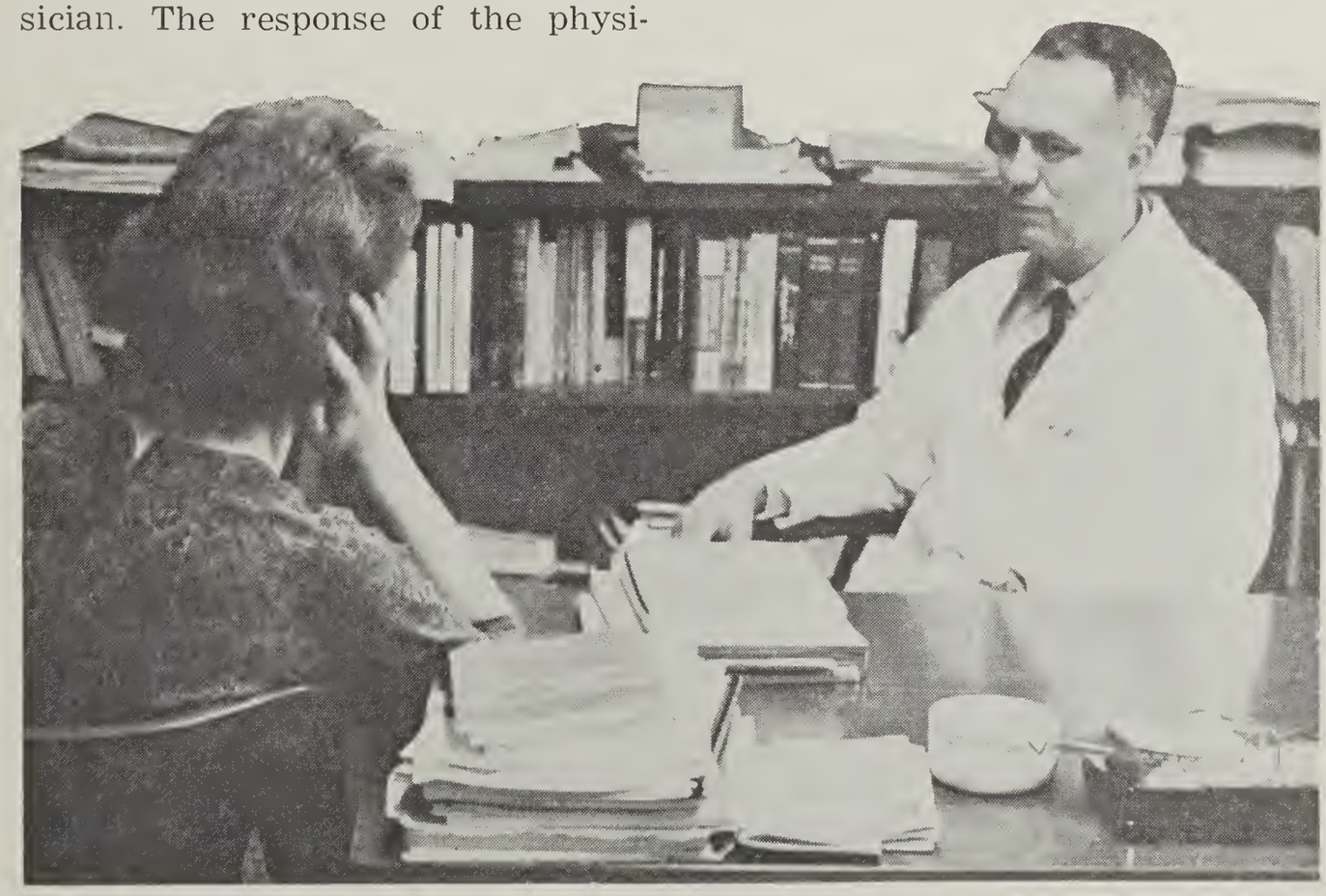
One improvement in the Center, and the most important in any rehabilitative program which deals with people, has been the acquisition of a full complement of professional staff. With additions to the staff of a psychologist and physician in September and October, the Center, for the first time in many a year, has a real multi-disciplined team approach to treatment encompassing the fields of psychiatry, medicine, psychology, social work, vocational rehabilitation, religion and recreation-avocational interests.

Admission policies were more consistently applied in 1963 with much emphasis upon proper medical referral to the Center by the family physician. The response of the physicians has been gratifying. Patients are coming to the Center in much better physical condition, usually quite well withdrawn from alcohol, and much better motivated to enter into the Center's life and treatment program.

As a part of our desire to have good communication with the local referring physician, discharge summaries giving the patient's history (including medical, sociologic, and psychologic evaluations) diagnosis, and recommendations for follow-up treatment have been prepared on each patient leaving the Center and sent to the referring physician. This had not been done previously and, according to reports from physicians receiving these summaries, they were much appreciated. The summaries are also a part of the medical record system of the Center which underwent an overhauling during the year.

Routine chest X-rays were added as a part of the patient's medical work-

(Continued on page 6)



A feature designed to help you keep posted on developments in the field of alcoholism.

NEW BERN, N. C.: A joint meeting of the Craven County Council on Alcoholism and the County Mental Health Association was held in New Bern on March 11. Theme of the program was "Focusing on Community Mental Health." State officials who attended the meeting included Dr. Charles Vernon, director of the Community Services Division of the State Department of Mental Health who spoke on "Changing Perspectives on Community Mental Health"; and Dr. Norbert L. Kelly, director of the Education Division, who spoke on the subject "Promotion and Prevention Through Education."

The meeting served as an occasion to bring together state and local officials working in the broad area of mental health in an effort to develop further interest in mental health.

AA RETREAT: The 14th annual retreat for men in Alcoholics Anonymous will be held June 5-7 at Vade Mecum near Hanging Rock State Park in the Sauer Mountains. Once again the Piedmont Diocese of the Episcopal Church of North Carolina has made its facilities available for the retreat.

RALEIGH, N. C.: Raleigh was the site of the Conference of County Medical Society Mental Health Committees March 14-15 and several NCARP staff members participated on the program. Dr. Norbert L. Kelly served on a panel on "Public Education" and Dr. Norman Desrosiers participated in a panel discussion on the subject of "Alcoholism."

The conference, sponsored by the North Carolina Medical Society, had as its theme the expanding role of the family physician in management and control of mental illness. Also stressed at the two-day meeting was the need for developing a network of community-based mental health services and facilities.

LAURINBURG, N. C.: A five-day study course on mental health, sponsored by the N. C. Mental Health Association, the N. C. Department of Mental Health, and St. Andrews Presbyterian College in Laurinburg, will be held at the College July 6-10. Mental health centers and associations throughout the state will serve as key resources for potential student teams from each community in the fields of public health, law enforcement, public welfare, and teaching.

Some topics to be covered in the course include "Mental Illness and Mental Health", "Personality Development", "Personality Structure and Defense Mechanisms", and "The Family", among others.

Lecturers and discussion leaders will include Dr. Norbert L. Kelly, Dr. Robert M. Prince of the Aftercare Clinic in Charlotte, and staff members of the N. C. Department of Mental Health.

YADKINVILLE, N. C.: Yadkin County has recently been awarded a grant by the NCARP to initiate a pilot project to carry on educational and referral services in a rural area. This rural project, to be conducted over a two year period, is the first of its kind to be established in North Carolina. It will be supervised by a twelve member board of directors, who have appointed Reverend James A. Haliburton as part-time director of the Yadkinville Alcoholism Information Center. Offices of the Information Center, which will be open on Tuesday and Thursday afternoons, are located in the County Courthouse.

RALEIGH, N. C.: Special problems of North Carolina's senior citizens will be brought to the attention of the public during the "Special Week on Aging" sponsored by the Governor's Coordinating Committee on Aging during the week of May 3.

NEW YORK, N. Y.: "Two Decades of Progress" will be the theme of the annual meeting of the National Council on Alcoholism, to be held at the Waldorf-Astoria Hotel in New York April 8-10. National leaders in the field will review advances and trends in alcoholism—its scope, research, treatment—Alcoholics Anonymous, official agencies, and in the voluntary movement. Featured speaker at the association's annual luncheon will be Wilbur J. Cohen, assistant secretary for legislation, Department of Health, Education and Welfare, who will speak on "The Federal Government Looks at Alcoholism."

CHAPEL HILL, N.C.: The second annual Summer School of Alcohol Studies for professional persons interested or working in the field of alcoholism will be held at the University of North Carolina June 7-12. Sponsors for the week's activities include the Alcoholic Rehabilitation Program of the N. C. Department of Mental Health, the U.N.C. School of Public Health, and the Alcoholism Programs of North Carolina. Students attending the school will live in two of the University's newest multi-storied dormitories—Craige and Eringhaus. All classes will be held in Craige which also houses a cafeteria.

Among the lecturers will be Dr. Norbert L. Kelly; Dr. William Thomas, chief psychologist of the N. C. Department of Mental Health; Dr. Fred Ellis, associate professor of pharmacology at the University of North Carolina School of Medicine; Dr. John Ewing, head of the psychiatry department at U.N.C.; and Dr. Hiawatha Walker, associate professor of health education at U.N.C.

The curriculum will include a study of the nature of alcohol and problems associated with its use; the symptomatology and treatment of alcoholism; problems of the alcoholic and his family; and workshops, films, and discussions.

NEW BRUNSWICK, NEW JERSEY: Instead of its traditional month-long course, the Summer School of Alcohol Studies at Rutgers University, in cooperation with the University Extension Division, will offer a series of intensive specialized courses in alcohol problems this summer.

Three major programs will be offered: A Physician's Institute for doctors who wish to be informed about current research knowledge and clinical practice in alcoholism; a series of 13 specialized courses for health, education, welfare, law enforcement, alcohol control, and pastoral workers, and a Northeast Institute, which will attempt to provide a general view of problems of alcohol and alcoholism for board members of official and voluntary agencies and civic leaders and officers, among others.

Raymond G. McCarthy will again serve as executive director of the school.

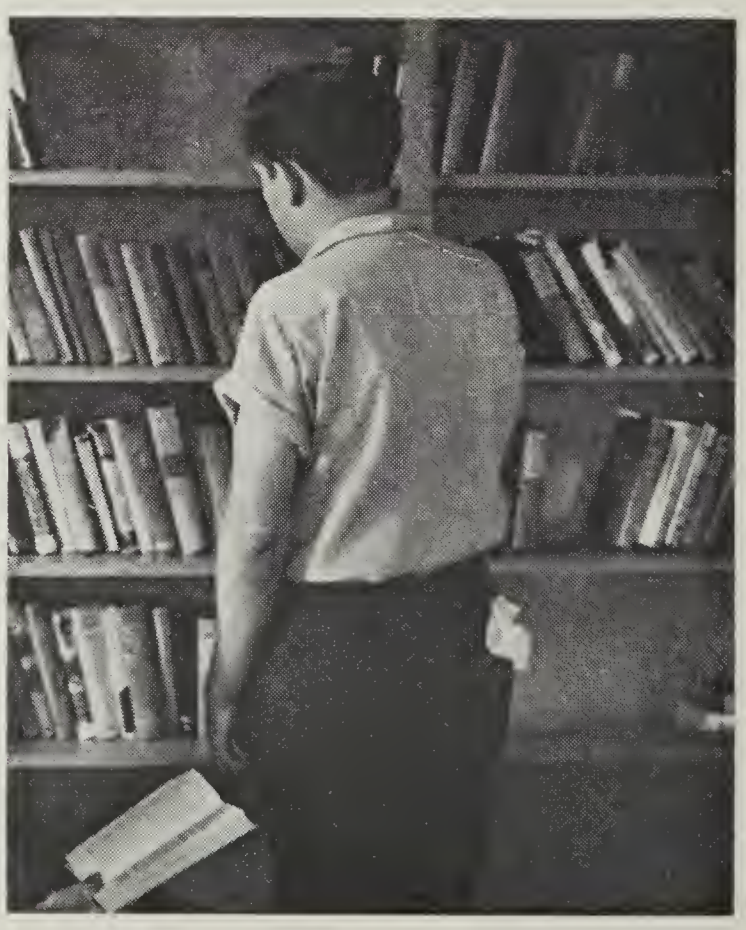
up because of the increased incidence of tuberculosis among alcoholics. One definite case was discovered during the year and several other cases of pulmonary pathology also were uncovered. We feel that this addition to the program is a necessary part of the medical management of the patients who come to the Center in the convalescent stage of their illness.

Major revisions were made in the actual treatment program of the Center. Previously, patients were treated in a mass group exercise each morning. In brief, the change has been to break this large group up into four smaller groups (up to 12 or 13) and assign a therapist to each group for the entire four weeks. Each of these groups, in addition to the sessions with their own therapist, is exposed to at least two sessions with every member of the professional staff in the subject area of that staff member's specialty. In this manner, each patient who is a part of a given small group has at least one hour and a half session five days a week for his entire stay. In psychiatric practice this amount of therapy is considered quite intensive and equivalent on an outpatient basis to 4½ to 5 months of therapy on a once-a-week basis.

Each patient is also seen in individual sessions as he may request or require in the opinion of his therapist. Some require more, some less. In any event, the net result is that the individual patient receives considerably more of the staff's time and a considerable amount of his own therapist's time. There is positively no substitute for this, and no therapy of any definitive sort can occur without it—a factor often forgotten in planning treatment programs. It is the recognition of this crucial factor that causes us to rejoice in the staff complement now at the Center.

That the professional staff who serve as therapists are competent in their fields is reflected by the fact that, during the year, the Center became a training center for clinical placements at the postgraduate level in three professional fields—social work, recreation, and pastoral care. Members of the staff also served in many training seminars and courses throughout the state. In addition, three articles by members of the Center's staff were published in *Inventory* and another article is to be published in the national journal, *Pastoral Psychology,* during the forthcoming year.

The emphasis upon a more intense and more individualized therapeutic program and a consistent admission policy has begun to show some tangible and measurable results. One has been the screening out of a number of poorly motivated individuals—those patients who show up at the Center for admission inebriated, for example, and who, after sobering up, inevitably leave after a very few days. In 1960, 1961 and 1962 this drop



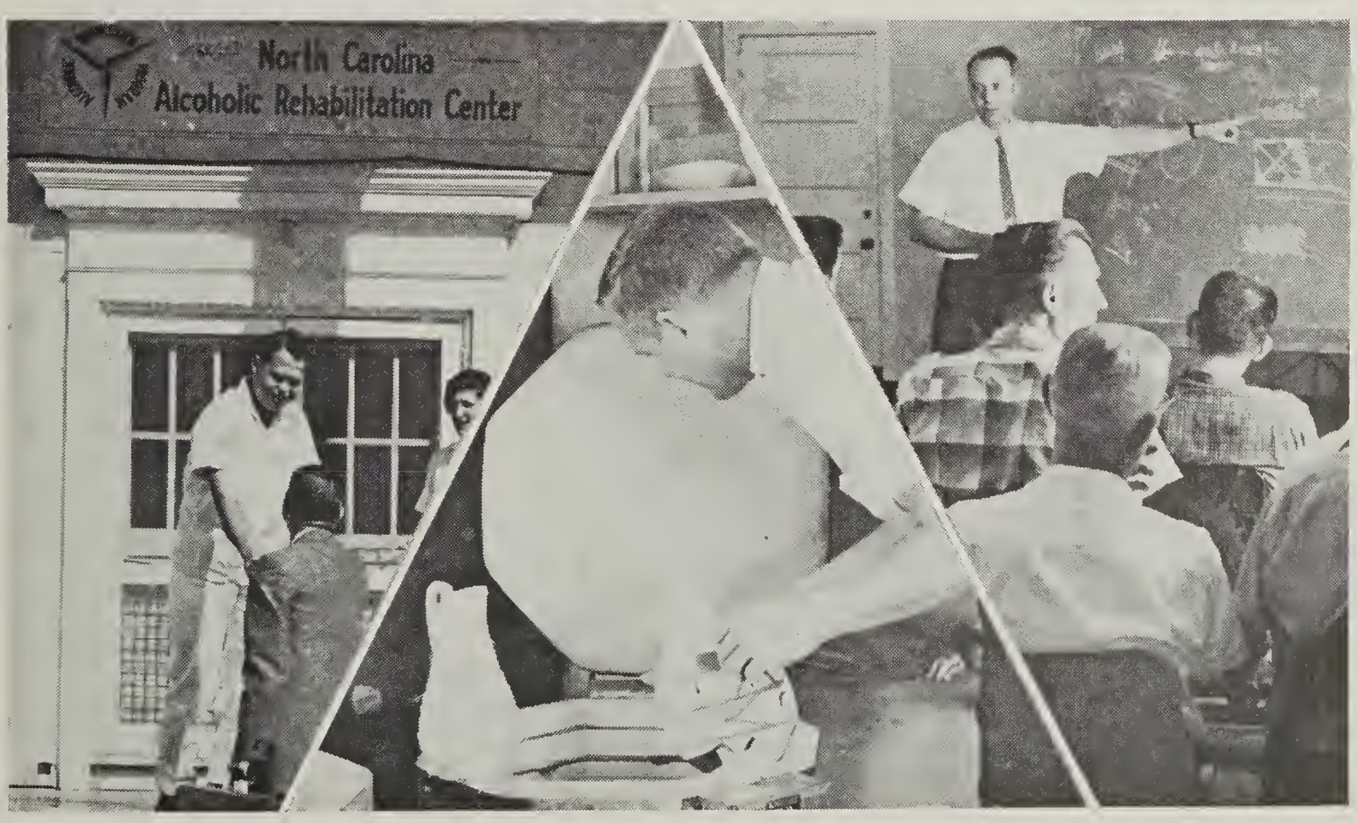
out rate on a yearly basis amounted to 27, 26, and 20 per cent, respectively! In short, from a fourth to a fifth of the patients were leaving the Center during the course of their stay, presumably not getting anything from the then existing program. In terms of time and money wasted, the loss was considerable. For the calendar year of 1963, this drop out rate was reduced to 6 per cent. In other words, 94 per cent of the patients admitted for treatment remained the full time to discharge. Moreover, 17 patients during the course of the year elected, with the medical director's permission, to remain for a second month of treatment.

Considering that we are dealing with a population as notoriously difficult to treat as the alcoholics who come to us as voluntary patients, the Center staff is proud of this record. A total of 405 patients were treated at the Center from January, 1963 to January, 1964.

The Center's physical plant experienced some reworking during the year. High on the priority list was the repaving of the front driveway which had been in terrible condition for years. This was accomplished in August of 1963, and the repair has improved the appearance of the Center considerably. The kitchen cabinets received new formica tops and a new paint job much to the dietitian's delight. A library for the patients, a much-needed facility for providing a quiet place to read and to write, was built in a corner of the large activities room. Called the Kinion Proctor Memorial Library in honor of the man who initially worked so hard to get the Center established, it has proved very useful and very popular.

Another improvement was the installation of a fire alarm system which is connected to an automatic sprinkler system as well as equipped with manual controls. A fire evacuation system was also developed at the same time.

The experience that is being gleaned throughout this country and abroad appears more and more to confirm the basic voluntary treat-



ment center approach to alcoholism that our Center embodies. It is common knowledge that the Florida Alcoholic Rehabilitation Center in Avon Park is a carbon copy of our Center and has proved highly successful and popular in that state. Word has come to us by way of Toronto, Canada that they are in the process of planning to build an inpatient treatment center according to a somewhat similar pattern as our Center. Also, in recent months, the West Virginia Commissioner of Mental Health, Dr. Mildred Bateman, toured the Center with her staff to explore the setup of our program.

As we look forward to future planning for North Carolina's Alcoholic Rehabilitation Center, much serious thought needs to be given to providing a new housing facility for the treatment program as it now exists. The present building, which has served well these 13 years, is rapidly coming to the end of its useful life and consideration must be given before the next Legislature meets to the necessity of building anew or rebuilding the present structure. It is regrettable, indeed, that the 1963 Legislature failed to appropriate any money requested for capital improvements to build a new unit. If it fails again to do so in 1965, then it can be anticipated that the Center, which has become a symbol of hope and help for countless alcoholic patients in North Carolina as well as having been an inspirational model for a treatment program for other states and nations as well, will find itself, by default, re-immersed within the state mental hospital structure, and completely lose its identity and effectiveness.

ADDITIONAL BEDS FOR ALCOHOLICS

THE Department of Mental Health is allocating additional mental hospital beds to alcoholics, according to Dr. Eugene A. Hargrove, Commissioner.

A change in law governing admission of alcoholics to mental hospitals has brought the increased demand for beds.

Under the old law, alcoholics were admitted to only two of the state's mental hospitals—Dorothea Dix at Raleigh and Cherry at Goldsboro. Now, they will be accepted at John Umstead Hospital, Butner, and Broughton Hospital, Morganton, as well.

In all, some 300 mental hospital beds will be allocated to alcoholics which will increase the treatment capacity from 2,100 patients to 3,600 patients per year.

The law as modified by the 1963 General Assembly considers the alcoholic an emotionally sick person and places him under the same admission requirements as the mental patient. This change also recognizes that the alcoholic may be indigent and yet urgently require treatment. The advance payment of a mandatory $75 fee which was in effect under the old so-called legal "inebriate commitment papers" no longer applies. The four procedures for the admission of mental patients and alcoholics to the mental hospitals are: voluntary, involuntary, medical certification and emergency.

The North Carolina Alcoholic Rehabilitation Center at Butner, though it operates under the mental health department, will continue to accept voluntary patients only.

"We see the need for even more beds for alcoholics," Dr. Hargrove said, "and we hope that the next Legislature will provide the necessary funds." In the meantime, he stressed the need for continued development of community resources for treatment of acute alcoholism and long-term rehabilitation.

VOL. 13, NO. 6 INVENTORY MARCH-APRIL, 1964

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

Clues to the Diagnosis of Alcoholism

BY RICHARD C. BATES, M.D.
LANSING, MICHIGAN

IN the United States at the present time, one adult in twenty is an alcoholic and cirrhosis of the liver is the 10th cause of death. The average physician probably encounters one or two alcoholics in his practice daily but few of us make the diagnosis that often. Yet, next to the traffic judge and the family, we stand in the most favorable position to do so.

Our failure is not surprising when the patient usually does his best to conceal the diagnosis and may be abetted by his family. Undoubtedly some physicians unconsciously avoid diagnosing alcoholism because of an emotional rejection of the alcoholic, feelings of guilt about their own drinking habits, or feelings of inadequacy in their ability to treat the disease. Many alcoholics are totally unaware that they suffer from the condition and consider for years that they are merely heavy drinkers who have had a lot of bad luck in life.

This article originally appeared in the October, 1963 issue of *The Journal of the Michigan State Medical Society*. It was reprinted and distributed by the Michigan State Board of Alcoholism and appears in *Inventory* with their permission.

A physician lists several easily discernable clues that may be helpful in diagnosing alcoholism in some patients seeking help for other illnesses.

Alcoholism is a disease—progressive, serious and potentially fatal. In the middle stages it produces a variety of social and physical phenomena that makes the diagnosis a thrilling challenge to test the mettle of those who pride themselves on diagnostic acumen. Yet, all too many physicians are only aware of the signs in the late stages when cirrhosis is imminent, little challenge is present, and even less chance for cure. The analogy of waiting until the appearance of hemoptysis to diagnose tuberculosis is obvious.

In the past two years we have had an opportunity to examine over 400 alcoholics from all walks of life admitted to our unit at E. W. Sparrow Hospital. This experience has educated us in picking up clues that sometimes suggest alcoholism in private patients coming to the office for other complaints.

At the start of the examination of a new patient, one's suspicions should be aroused by a sulky, uncooperative male who states his wife nagged him into an examination. The alcoholic as a rule is depressed, tense, self-centered, hypochondrical, impulsive, hostile, and immature. The present illness will usually display many of these traits and the family history may be revealing in that, if your patient is a child or sibling of an alcoholic or cirrhotic patient, he has a 50-50 chance of alcoholism himself.

The past history may occasionally yield the picture of several automobile accidents, a gastric resection for intractable ulcers or pancreatitis. The ulcer patient who admits to regular social drinking is a suspect. Alcoholics have five times as much tuberculosis as the general population, and half the patients in a sanatorium are alcoholics.

Naturally the social history will be most fruitful. You may not wish to take such a full history on every patient, but if the thought of alcoholism enters your mind at any time during an examination, you will be well-advised to inquire into the following:

1. A patient without a high school education: 55 per cent of our patients dropped out of school before getting their high school diploma. This is a sign of immaturity and impulsiveness—two characteristics that cripple the alcoholic for many years. The school gadfly often metamorphoses to a bar fly.

2. The man who changes jobs frequently: a third of our patients have had more than five jobs in the last ten years.

3. The man who holds a position well below his obvious education and ability.

4. The executive in a good position who takes an inferior job with a smaller company.

5. The self-employed man who goes into bankruptcy.

6. The apparently healthy man who is unemployed.

One of our most significant statistics is that two out of three of our male alcoholics are not living with a wife when we first see them, but are bachelors or divorced men living alone or with other men. Only one in five of our patients is still living with his first wife and 10 per cent are bachelors. Roughly half of all divorces are thought to arise from alcoholism. Whenever you hear that two of your patients are divorcing, ask each if the other drinks too much.

A history of excessive cigarette smoking (arbitrarily placed at more than a pack a day) was present in a little over half of our subjects which suggests that it would do no harm to inquire about the drinking habits of

any heavy smoker, particularly if he has visible tar stains on his fingers, as occurred in about 60 per cent of our patients.

One should always ask suspect patients about alcohol habits and take a careful, gently persistent, thorough history until he is satisfied that he knows when, how often, how much and for what reasons his patient drinks. Any hint that he "sometimes" drinks "too much" or "more than I should" or "more than my wife thinks I should" argues strongly for the diagnosis. Any patient who asks if he might be an alcoholic or who says that he sometimes thinks he is an alcoholic is offering the physician a clue in hopes that it will be taken up and discussed. Sometimes the statement will be made in such a way that the physician's instinctive response will be one of reassurance, but if he falls into the trap of telling the alcoholic that he is *not* alcoholic he may do tremendous harm and perpetuate the disease for months and years. We have seen some tragic results where patients have been reassured that they were not alcoholic but neurotic, and that their heavy drinking was only a symptom of tension, thus enabling them to drink with renewed vigor while fending off their wife's protests with an authoritative proclamation from the doctor that it was "all right."

Roughly, a person who admits to eight drinks in the course of an evening is probably an alcoholic. No absolute limit can be stated since factors of body weight, stomach content, time lapse and liver function all modify the blood alcohol level. It must be remembered that one usually forgets precisely how many drinks he's had after six drinks and most people will shave their estimates by several drinks. After the age of 25, male social drinkers seldom get drunk, women almost never. For normal people, drunkenness is an unpleasant experience and the social drinker can and does avoid it.

When this line of questioning begins to pile up evidence that one is, indeed, dealing with an alcoholic patient, he can then ask if the subject has ever been threatened with loss of job or marriage because of drinking or been arrested because of drinking or drunken driving. A positive answer to any of these is virtually conclusive. In our patients from all walks of life, five of six have been arrested at least once and four of six more than once in their lives. Hospitalizations for drinking or bouts of delirium tremens generally indicate the later stages of the disease.

Signs and Symptoms

On physical examination, look first for shabbiness, poor hygiene, and poverty below a man's position, education, and social background. A red face or acne rosacea is a sign which should be investigated as to cause and may be, though not necessarily, a clue to alcoholism. Alcohol is more vasodilating to the alcoholic than to the social drinker. Periorbital edema, bags under the eyes, scleral edema and nystagmus on lateral gaze all suggest a hangover. Coarse tremor of the outstretched hands occurred in 80 per cent of our patients.

If a palpable non-tender liver can't be explained by cholecystitis, diabetes, emphysema, or obesity, it strongly suggests alcoholism—55 per cent of our patients had a palpably enlarged liver.

Bruises in unusual spots—other than the thighs and shins—are frequent and come from lurching around the room in a drunken state. Alcohol on the breath need scarcely be mentioned as an important clue. The man who stops on the way to

the doctor's office for a drink may be taking alcohol as a tranquilizer.

Women provide a particularly difficult problem in the diagnosis of this disease. The female patient who calls you at home evenings or in the middle of the night and talks endlessly, repeats herself, and makes flattering personal remarks is probably drunk. Home accidents, fractures, and falls in women under 65 may be the first and only clue to the female alcoholic. Quite suspect is the person who is injured in a home accident but fails to report for medical attention for several hours or days later because she "didn't want to bother you in the middle of the night" or "it didn't hurt at first." In truth, she didn't want you to see her drunk or didn't feel the pain or realize she was injured until the alcohol wore off.

On house calls, you may observe poverty and shabbiness not in keeping with the income level of the breadwinner's job. Working wives often denote drinking husbands. Able-bodied men on relief may be alcoholic, as well as the supposedly well-to-do patient who doesn't pay bills promptly and the man who calls and says he's been off work three days with a "cold" and asks you to fill out a slip so he can return to the job—even though you have not seen him in the office.

In the hospital, the patient who becomes critical of his care, agitated and restless and signs out in anger may be having a withdrawal reaction. Increase his sedation and he may stay. Persistent unexplained tachycardia is a most important clue. A grand mal convulsion in an adult with no previous history of epilepsy, occurring 24 hours to 48 hours after admission, may be a "rum fit." If it occurs from the second to the tenth day, consider barbiturate addiction as well. Unexplained delirium in a hospital patient is usually delirium tremens.

Office patients who call for tranquilizers and sleeping pills at intervals indicating that they are doubling up on the dose you prescribed have addictive tendencies and will probably be found to use alcohol in an uncontrolled fashion, too. Outpatients on anticoagulants whose prothrombin times fluctuate widely may be drinking heavily.

Finally, think of the diagnosis whenever you encounter a situation that puzzles you; where the relatives seem to be holding something back or you have an uncomfortable feeling that you don't fully understand what's going on in a patient's mind and life. Ask the unhappy, sulky teenager, the depressed premenopausal mother if there is one of these problems in the home.

Summary

The diagnosis of alcoholism is a constant challenge. Possibly no other common illness is so frequently missed. Yet many clues are present in the usual case. Whether or not a physician is interested in alcoholism, he cannot afford to shut his eyes to a condition that afflicts 5 per cent of our adult population and shortens life expectancy by 15 years. If he makes the diagnosis, a number of sources are available to him for help. In our experience if a patient who has the disease is apprised of the diagnosis and guided to help by an understanding physician, he and his family will be eternally grateful and the physician will reap as much self-satisfaction as though he had detected an early cancer. Listed here are many clues, easy to discern, which have proved helpful in the diagnosis at a stage when there is at least a 50 percent chance for permanent arrest of the disorder.

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Bi-Monthly Journal on Alcohol and Alcoholism

March-April, 1963 through March-April, 1964

Indices have been published previously

in the

May-June, 1961 and 1962 Issues

and

Succeeding March-April Issues

THE ADOLESCENT IN AMERICAN SOCIETY

PART II

BY NORBERT L. KELLY, Ph.D.

ASSOCIATE DIRECTOR

ALCOHOLIC REHABILITATION PROGRAM

N. C. DEPARTMENT OF MENTAL HEALTH

Much of the difficulty in understanding the adolescent comes from conflict over the fact that he is grown up and yet he really isn't grown up.

The Adolescent in American Society was presented by the author at a conference on *Youth and Alcohol Education* held in the Summer of 1962 at St. Andrews Presbyterian College, Laurinburg, N. C. It, along with *Youth and Alcohol Use,* was published in two parts, the first of which appeared in the January-February, 1964 issue of *Inventory.*

I HAVE just stressed that many parents define certain standards or expectations for their adolescents. Many adolescents see these and other efforts at control as being overly restrictive. Perhaps the most common complaint of youth, as revealed in numerous research projects, is that their parents too frequently treat them as children. They want their parents to be less restrictive. Believing themselves to be far more adult than they are given credit for, they resent the attitudes of unquestioned authority that many parents assume toward them. These feelings are shared by more than three-quarters of American adolescents.

Conversely, teen-agers desire more intimate, personalized communication with their parents. They ask for more parental counsel. They

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YOUTH AND ALCOHOL USE

PART II

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Research is making it increasingly less necessary to speculate about what young people are thinking about, and what they are doing with, alcohol.

Youth and Alcohol Use, which was also presented at the conference on *Youth and Alcohol Education,* is presented as a companion article to *The Adolescent in American Society.* Copies of the entire proceedings of the conference are available on request to interested persons, particularly those who are concerned with the education of youth about alcohol.

AN individual is never introduced to culture in general but rather to the culture as lived by the significant individuals in his experience, as I have noted. For almost all individuals, the significant persons to whom he is exposed first, longest, and most intimately are adult members of his kin group. Therefore, what a child comes initially to think about and do with alcohol reflects in large measure what these significant adult role models in his kin say about and do with alcohol. Some of this teaching and learning, although subtle and implicit, nevertheless tends to legitimate the idea of alcohol use: Alcohol is kept in the home without apparent secrecy, shame or guilt and is consumed on a wide variety of occasions without apparent misfortune and with much apparent enjoyment. Some of the teaching is explicit. Oc-

casional experimental "tasting" of alcoholic beverages by children may be tolerated or even encouraged and parents may specify the conditions under which drinking will be permitted by adolescent members of the family. These are probably the experience of a majority of young people in our society.

A persistent minority of young people are exposed to a teaching-learning situation in which the significant adult role models to which they are initially exposed are abstinent. In many subtle and obvious ways, a style of life into which alcohol is not integrated is transmitted between generations.

This description of how drinking and abstinence as styles of life are transmitted between generations is, of course, overly simplified. The process of transmitting family culture to an offspring is complicated by the other agencies of socialization.

The age-peer group is the most obvious example of an agency of socialization which achieves special significance during adolescent development in our society. The contemporary adolescent does occupy an anomalous position in the social structure. He is no longer a child but not yet an adult. During the relatively long period between puberty and the achievement of adult status, he must orient himself to "play at" adult roles without, at the same time, being allowed to play them fully. He must learn to behave as adults presumably behave, but at the same time develop a keen sense of timing and of adult-imposed limitations on his experimentations.

Some observers of the American scene describe adolescence as a time necessarily associated with stress and strain which, in turn, produce a "youth culture" and peer groups antagonistic to adult authority and goals. While this interpretation is certainly plausible, it has not been rigorously tested; the evidence, such as it is, is ambiguous. Moreover, the description of drinking among young people which was presented at the beginning of this paper appears to be negative evidence.

One can admit without hesitation that some drinking by adolescents surely reflects hostility toward adult authority and goals. Drink may be used as a test of loyalty to peer groups precisely because it is discouraged by adults. However, the contrary evidence is compelling. The probability of alcohol use increases with age, that is, as the assumption of adult roles is approached. There is a demonstrated relationship between the drinking behavior of parents and their offspring; and given what we know about the importance of parents as models for behavior, a majority of adolescents in our society would in all probability come to use beverage alcohol eventually even if there were no peer group experience at all. Young people tend to perceive some drinking as an integral and legitimate part of normal adult behavior. The emphasis of this evidence is overwhelmingly on adolescent identification with adulthood, not hostility to adult goals or authority.

While for some young people peer group participation may be an occasion for exposure to alternative models of behavior not observed in the parental family, there is an observed tendency for cliques to form among adolescents, on the basis of similarity of life style developed in the parental family. And, to the extent to which this is the case, peer group drinking behavior among adolescents would tend to reflect that of

tyles of life are culturally transmitted between generations.

the parental models, though perhaps in caricature and to an extent that parents would consider premature and excessive for the adolescent. There is simply no evidence that an abstinent adolescent is inevitably seduced by his peers who drink or that peer group drinking is typically unrestrained by group norms. Research has not clearly identified all the mechanisms which function to keep the non-drinking adolescent in bounds. But the fact remains that a large minority of persons in our society remain abstinent throughout adulthood and unrestrained drinking is not typical even of organized delinquent gangs. Both non-drinker and drinker can and do find support from peers, but in the case of the drinker this support is ordinarily conditional. The myth of inevitable and irresistible peer group pressure to drink and to drink excessively may tend to become, unfortunately, a kind of self-fulfilling prophecy.

The impact of the mass media of communication on what young people think about and do with alcohol also needs critical review. Like age peer groups, the mass media have the characteristics of exposing an adolescent to alternative models of behavior which do not necessarily support the parental model. In a complex society this problem of confronting young people with alternative and sometimes contradictory models of behavior is, of course, not confined to the use of alcohol alone. Books, magazines, radio and television continually suggest to the adolescent alternatives in religion, politics, ethnics, clothing and style of life in general without their necessarily being mediated through parents.

This observation has led some persons to conclude that the mass media are or can easily become agencies of evil aiming at the destruction of the moral fiber of society, with "liquor advertising" being a case in point. There are no carefully controlled studies demonstrating the relationship between the prevalence of drinking and liquor advertising. However, on inferential grounds, a close relationship would not necessarily be expected. The assumption that individuals can be manipulated simply by subjecting them to mass media is overly simple and misleading. It is increasingly apparent that knowledge of the interpersonal environment of the individual is basic to understanding both what exposure to mass media stimuli means to him and what his response to that exposure is likely to be.

The effect of the mass media cannot be totally discounted. At a very minimum, advertisement of beverage alcohol, both direct and indirect, does suggest the legitimacy of some drinking for normal adults and might well reinforce the prevalent misconception that alcohol is a social beverage much more capable of doing something *for* the user than *to* him. Such suggestions would tend to reinforce the acceptance of drinking behavior on the part of adolescents whose interpersonal relations in family and peer group had already oriented him to drink. It remains to be demonstrated, however, that the mass media are crucial in transforming into a drinker an abstinent young person whose interpersonal relationships in family and peer group did not reinforce the suggestions about

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Seminary Students Write

We are students at Southwestern Baptist Theological Seminary and are very interested in the ministry to alcoholics. Your magazine has been a great help to us. Please place us on your mailing list.

L. Kelly and
D. A. Winkelmann
Fort Worth, Texas

Wants to Help Others

Would you please add my name to your mailing list? I am an alcoholic; recently I joined the AA group here in Salisbury and I find your journal of great help in trying to understand more about this illness and its various aspects. So little is known by the public, unfortunately, that I am thankful to find a magazine that covers so many baffling aspects of what has afflicted me so long and has well nigh ruined my life and my family.

If possible, send me the ARC Brochure and *The New Cornerstones*. I am not satisfied with simply arresting my alcoholism, but I want to know why and learn as much about it as possible in order not only to help myself understand but to try to help others if I can. I am sure *Inventory* will be of great assistance.

A Young Wife and Mother
Salisbury, N. C.

Former ARC Patient Writes

Yesterday I passed my 9th "birthday" and so much of these past years I owe to you and the North Carolina Alcoholic Rehabilitation Center. As former "guest" #98, my experiences there were a major factor towards my recovery when all else had failed.

A loving marriage has ensued and how proud I am of our newly acquired home, but not too proud to have your *Inventory* delivered right to my door. So please change my address and who knows, perhaps even the mailman will read it and pass on the word that there is hope for people like me.

Anonymous
Santa Barbara, Calif.

New Alcoholism Clinic

I have just had the rewarding experience of reading the January-February issue of *Inventory*. The staff of the newly created Alcoholism Clinic in Baltimore City would be most appreciative of the opportunity to review your publication regularly and hope that you can put us on your mailing list.

Sylvia Lurie
Psychiatric Social Worker
Alcoholism Clinic
Baltimore, Maryland

Teen-agers and Alcohol

In March, the West Chowan Baptist Association is sponsoring a Youth Night under the theme "Youth Looks at Alcohol." I have been asked to lead a discussion group on this night and would like to know if I might obtain information concerning teen-agers and the alcohol problem. Any information you might be able to give or any direction as to where such information might be obtained will be greatly appreciated.

Rev. A. H. Lanier, Jr.
Pastor, Woodland Baptist Church
Woodland, N. C.

The Physician's Role in the Treatment of Tuberculosis-Alcoholism

BY DONALD J. OTTENBERG, M.D.

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This article, reprinted by permission of the author, was originally presented at a workshop on "Intensive Treatment For the Tuberculous Alcoholic Patient" sponsored by Firland Sanatorium, the National Institute of Mental Health, and the Washington State Health Department in Seattle, Washington, April 12 and 13, 1962.

Establishing and maintaining a warm, genuine relationship with the patient is of primary importance.

THE past twenty years have witnessed profound changes in the doctor-patient relationship in the treatment of tuberculosis. Before the development of effective antituberculous drugs there was very little of a specific nature that the doctor could offer to the patient. The prognosis was very grave compared to what it is now, and the patient saw the hospital as his only hope of recovery. Then, the doctor who specialized in tuberculosis work took on many of the aspects of God in the patient's eyes. The patient reached out his hand for help, and if the doctor took it, the patient was willing to accept almost any regimen prescribed, feeling that it was his best and possibly his only chance of salvation. Patients stuck to treatment better and longer, even though the discipline required was much more stringent than it is today. Utter need bred utter faith.

Now the patient arrives much less dependent on the hospital, much less certain that the doctor is the indispensable source of help. And, with the waning of the tuberculosis epidemic in the country, more patients come from those segments of society which have serious social and psychological problems. These problems complicate the illness. The doctor must treat more difficult patients at a time when it is much more difficult to establish rapport. He must combat not only tuberculosis, but also those other pathological conditions which thwart the effective treatment of tuberculosis, among which alcoholism stands at the top of the list.

In an era that accepts treatment of the patient-as-a-whole as a fundamental precept, there is no need to justify treatment of the alcoholism as well as of the tuberculosis. The patient's health is the goal and justi-

fication of any treatment. If pragmatic justification were required it is easily obtained from the high tuberculosis relapse rates among alcoholics. Treating the alcoholism is simply part of treating the tuberculosis. Certainly this is true of the Skid-Row alcoholic. To return him to Skid Row after treating his tuberculosis is to assure the failure of treatment.

The physician's obligation to treat the alcoholism as well as the tuberculosis would be a lot easier to fulfill if the treatment of alcoholism were as specific, as tangible and as amenable to clear exposition as is the treatment of tuberculosis. I believe that the reluctance of many physicians to attempt to treat alcoholism stems from the very nebulous character of the treatment. I can sympathize with the physician who, almost in exasperation, says, "Stop exhorting me to treat alcoholism and tell me what the treatment is." This is not easy to tell, but I shall try, if you will understand that I do not pretend to speak as an expert—simply as a physician who has had the interest to look into the problem and the temerity to try to cope with it in individual patients.

I cannot claim that my way of treating patients was successful, since the number is comparatively small, and there has been no prolonged follow-up and no rigid criteria of success or failure have been applied. All I can say is that my therapeutic relationship with the patients seemed to be important in keeping them under treatment for their tuberculosis and, in some, seemed to contribute toward freedom from drinking and a greater degree of self dependence. This is not the description of a program, for there was no formalized program in the tuberculosis hospital in which these patients came under my care. Simply, I did what seemed natural and reasonable in an effort to help the patient. Now I am looking back in an attempt to define what I did. If some patients were helped—and I think some were —I can't say why they were helped. But for practical purposes I don't think that matters.

I feel that establishing and maintaining a genuine relationship with the patient is of first importance. For these patients the relationship itself seems to be therapeutic, without regard to the specific verbal exchange. This does not deny that the relationship can help the patient specifically. Certainly some patients gain insight into their predicament, some are educated in the meaning of alcoholism and Skid Rowism. Some appear to be motivated to help themselves and most derive emotional support and protection from the relationship with the doctor. In the long run some alcoholics, like other emotionally ill patients, seem to treat themselves. At least the change that occurs is internal and indefinable. It may be that the unfailing interest and concern of the doctor makes the patient appreciate, consciously or unconsciously, that it may be possible to change. The mere presence of someone who truly cares whether he succeeds or fails may supply an incentive that never existed before. Though he may not say it or ever know it, the alcoholic, like practically everyone else, wants to be valued, accepted and loved. The physician may not be able to help in specific terms at every step along the way. Simply sticking by the patient as he moves forward and back, or doesn't move at all, may be the best kind of help the physician can offer.

ourself, control yourself, give yourself."

Numerous other therapeutic processes and relationships may contribute enormously or very little to the patient's progress. Group therapy, group education, occupational therapy, vocational guidance, sheltered workshops, community activities, Alcoholics Anonymous—any or all of these may help the patient to understand himself and his illness, to recapture his self-respect, to experience the pride of accomplishment, to know the inner satisfaction of being responsible for himself. And yet, the mere availablity of all these activities and services is not enough. The opportunities are open to the patient. It is the physician's role to help the patient become open to the opportunities.

You may well be asking exactly what kind of physicians do I have in mind. A few years ago I attended a conference to discuss the enforced isolation of tuberculous patients. I argued vehemently against locked wards as usually being morally unjustifiable and therapeutically unsuccessful. I suggested that forcible isolation might not be necessary if we had comprehensive treatment programs and facilities staffed by carefully selected, properly oriented and dedicated doctors, nurses and other personnel. A voice of derision from the opposite camp said that I wanted angels for nurses, saints for doctors and a hospital built on a cloud. Since there is something of a saint, as well as a devil, in most of us, maybe that isn't so far off the truth.

At the same conference, the meeting was opened by Dr. John Zarit of Denver who asked the conferees to recall that Socrates' last words were "know thyself," that Marcus Aurelius' finest words were "control thyself," and that David's most beautiful words were "give thyself." If I can add to these simply "know thy patient," the instructions to the physician would be complete. Know your patient, know yourself, control yourself, give yourself.

What does it mean to know the patient? It is entirely possible to treat successfully a tuberculous patient in a hospital for several months and know no more about him than his name. age, sputum status, the appearance of his chest x-ray and his location in the hospital. This sounds facetious, but I am sure that many doctors know very little more of any significance about the person hidden in the patient. What is his social background? Where was he born and in what circumstances? What kind of father and mother did he have? In what kind of environment did he grow? What critical problems did he face as a child, adolescent, adult? What kind of family has he, if any? Did he leave his wife and children? Why? What kind of education did he have? Has he a police record? What is his religion? Has he vestiges of faith even though he doesn't attend church? Is he lost and detached from society? When did he start to drink? Why? What is the pattern of his drinking now? How does he feel about his drinking? Were there psychological tests? What did they show? What sort of work experience and record has he? What did the psychiatrist think of him? Is the patient running away from something or towards something? If so what?

Many other meaningful questions could be asked. The answers fill out the portrait of a person who is the

only one of his kind in the world. Knowing such answers about a patient, one can no longer see him as just another patient with tuberculosis and alcoholism. He becomes a person, more than just the sum of his organic parts.

It would be presumptuous to dwell on the admonition to "know thyself." The physician who feels secure and satisfied in his professional work does know a good deal about his own motivations, his fears and conflicts, his strengths and limitations. Part of knowing oneself is to know the image that is seen by others, including one's patients. Is it a real or fanciful image, and which image does one foster? The physician who will treat tuberculous alcoholic patients should not put a foot inside the hospital without fathoming his own feelings and attitudes towards alcoholics and Skid-Row inhabitants. Perhaps the feeling is nameless fear or embarrassment, inadequacy or hostility. Has the physician a score to even up with alcohol because of himself, a close relative or friend?

Self-control is usually thought of in extreme situations when one is acting under the influence of strong emotions or impulses. In the physician's role, however, self-control usually has to do with much less intense situations. Allowing the patient to take part in formulating his treatment and rehabilitation program requires self-control on the physician's part, as does the willingness to grant patients the right to say "no." This is not to suggest that recommendations ought to be given half-heartedly, without force of convictions. Far from it. I feel that physicians should use every nuance of persuasion in attempting to move patients to do what is best. But, if the answer finally is "no," the physician should not feel personally rebuffed, or react with rancor or vindictiveness.

Most patients go through a negative phase at some time during hospitalization, a period when their feeling of anger, resentment and frustration are expressed in hostility, usually directed toward the doctor. If the doctor takes this as a personal attack against him, the relationship with the patient may be impaired. The doctor must understand that he is just a symbol of the many insults and injuries the patient is raging against. If the doctor maintains his equanimity, the rage will pass.

Perhaps the most difficult instruction of all is to "give thyself." Certainly it is the most difficult to talk about. Every doctor gives every patient something of himself, so it is a matter of degree. It has to do with confronting the patient in a person-to-person relationship, even within the doctor-patient relationship. Most patients are quite sensitive to our reactions to them. They know when they are being handled and looked upon as a package of organic tissues, reflexes, bad habits and ignorant notions. Direct supportive therapy or relationship therapy of the kind intended here depends on human warmth and trust. Viewing the patient as an object, rather than as a being, even if unconscious on the physician's part, creates no warmth and engenders no trust. Giving oneself does not mean becoming emotionally entangled with the patient. One does not have to be friends with a patient or a pal, any more than a giving parent needs to be a pal rather than a parent. The patients know the rules of the doctor-patient encounter and with few exceptions they abide by them. If they don't, the doctor should set them straight. But they want something that goes beyond the call of duty. They want the solicitude, interest, freely-given

time, attention and sympathy that leaves no doubt that the doctor's concern for them exists in its own right and exceeds the mere fulfillment of a job. Even disciplining the patient may be a way of giving, providing the physician has earned, and not just assumed, the right of discipline.

A year or so ago I offered some suggestions to guide the personnel of a tuberculosis program that has to deal with alcoholic patients. This list helps to define the point of view underlying my interpretation of the physician's role in treatment of the tuberculous alcoholic:

Guidelines For Staff

1. Alcoholism is a disease or symptom of disease—not a crime. It is a medical, not a moral issue.

2. Recognize and accept the great personality and cultural differences that separate staff and patients.

3. Bear in mind that serious obstacles to communication exist and always try to see through the patient's eyes and hear through the patient's ears.

4. Remember that the patient really doesn't want to be the way he is, even when he seems to accept and almost welcome his fate. Most have long since stopped arousing the guilty "inner man" as much as possible. Many have never been outside the jungle of alcoholic living and know no other way of life. Most expect nothing but failure and so never attempt to change.

5. See yourself in relation to each patient—ask yourself if your decision and/or action is for your own needs, or for the patient's.

6. Accept reasonable goals for treatment in each case and avoid the frustration of overzealousness and overreaching. The tuberculosis hospital should not ignore the alcoholism and psychic disturbance, but it should realize its limitations in bringing about a change. There is no such thing as "total cure," neither in tuberculosis nor in alcoholism.

7. Define the goal of treatment in each case and judge crises, setbacks, and the patient's aberrant behavior objectively in the light of that goal.

8. Derive satisfaction from achieving part of your goal.

9. Be wary of generalizations, especially those used to justify repressive rules:

"You must make an example of him."

"If you let one get away with it, all will do it."

"If you give one a pass, all will want one," etc.

10. Don't be afraid to stretch:

—Stretch your *imagination* in trying to see the world as it looks to the patient.

—Stretch your *ingenuity* in trying to establish rapport with the patient.

—Stretch your *compassion* when you must sit in judgment—here, above all, keep your eye on the goal. (Should the patient who went AWOL be allowed to return? Should the patient who got drunk on pass and returned in a semi-liquid state be taken in? Should the patient who quarrels with a nurse be expelled?)

11. Finally, keep a *sense of proportion*—which is the same as a *sense of humor*. Tuberculosis is a grim disease and alcoholism, with all its fleeting moments of hilarity, is still a drain through which most of the joys of life escape. I can think of nothing that patients are more grateful for than to laugh with you. Humor, I think, is one of the sharpest weapons we have to pierce the defensive isolation of the alcoholic. A patient who smiles with you and then laughs with you cannot remain distant and inaccessible for long.

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the desirability of drinking to which the mass media expose him.

The importance of relationships in family and peer groups in determining whether or not alcohol is used would also explain in large part why religious and educational organizations committed to the achievement of total and permanent abstinence as the most desirable state of affairs have had such little success in transforming the drinking adolescent into an abstainer. Their efforts rather frequently encounter the obstacle of family and peer group support for some drinking.

I have repeatedly emphasized in this paper that adolescents do not invent the ideas of drinking or abstinence. They learn them, and learn them primarily through experience with parents and peers. Most adults, and by implication sooner or later most adolescents, learn to drink. Their drinking typically stays within the normal range and creates no special problems which interfere seriously with their personal and social functioning.

There is no simple, single explanation of why the behavior of some drinkers continually falls outside the normal range and it is not possible here to review the alternative explanations. There is widespread agreement among students of pathological drinking, however, that the roots of such behavior lie deep in childhood and adolescent experience of an individual and that inconsistency in and ambivalence toward alcohol use within a society increases the probability of pathological use. The relation of this observation to how adolescents learn to drink warrants at least brief comment.

For most young people, models of behavior encountered in the family and in peer groups tend to be more or less consistent with one another and therefore to reinforce one another. Rather obviously, parental models are sometimes inadequate; ambivalence and inconsistency may characterize the response of parents to alcohol. For a variety of reasons peer group values and behavior may not reinforce parental values and behavior. There is little question that the heterogeneity of values in our society with regard to alcohol use and the high degree of mobility experienced within our society maximizes the possibility of conflicting attitudes toward alcohol use and, then, to problems associated with alcohol use.

In a word, I am aware that Americans have more problems than most with alcohol and that social change and cultural heterogeneity contribute to and complicate these problems. However, this should not obscure the basic point of my presentation: Young people in our society do not invent the idea of drinking; they learn it. The fact that some of them learn the wrong things certainly provides an occasion of inquiring about what has gone wrong in the learning process. But the existence of drinking pathology among a minority of drinkers should not mislead us into treating alcohol use that stays within the normal range as though it is merely a prelude to later abuse or pathological use.

Young people learn ideas about drinking in much the same way they learn about food preference, cigarettes, dating, or driving an automobile. And they learn them primarily from the same people—parents and peers with support from other institutionalized groups.

For most young people in our society, alcohol use is an integral

part of the culture to which they are exposed. Drinking is not presented to them as a pivot around which life revolves; rather it is presented as part of a style of life, a relatively satisfying means of relaxing and relating themselves to the world around them. Typically, they learn how to drink, what to drink, when to drink, where to drink, and with whom to drink. Consequently, drinking abuses, although they do occur, are not typical among adolescents. Most of their drinking reflects identification with adulthood rather than rejection of it. For the young person whose parents are users of alcohol, *when* he may legitimately drink is more likely to be a problem than *whether* he may drink.

Not every young person learns to drink. A persistent minority maintain their abstinence into adulthood. Drinking does not become a part of their life style, of their way of relating to the environment.

Thus, in our society there is not a single, cultural tradition with regard to drinking to which young people are exposed. There are two persistent traditions and American communities have been, and occasionally still are, divided by arguments about whether alcohol use and abstinence can exist peacefully side by side. The relatively long period of adolescence and confusion about when adulthood is achieved cloud the issue even when some alcohol use is considered legitimate for adults.

These are some of the facts about alcohol use among youth exposed to American culture. These facts do not in themselves tell us whether there should be alcohol education, or if there should be, what kind. But this kind of information should be our starting point and continuing reference point in planning for alcohol education.

THE ADOLESCENT

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would like their parents closer to them, especially older adolescents.

During *preadolescence* most young people confine their social relations largely to their own sex. Beginning around the age of fourteen, this pattern begins to change. Youth interests begin to include relationships with the *opposite sex*. No doubt this change is partially motivated by an increasing sex drive and partially by cultural expectation that the time has come to learn to relate socially to members of the other sex.

It is becoming apparent that an additional stimulus to heterosexual relations, and at an earlier age, may be at work. Some parents seemingly are pushing their youngsters into earlier opposite-sex contacts by creating social situations that require participation by both boys and girls. Most frequently, some believe, this results from the concern of mothers about the popularity of their daughters.

For many adolescents these new relations create new problems. How far should one go in love relations? When is it all right to neck? To pet? Now that I'm old enough to date, why can't I stay out later?

New problems of how much make-up the girl should wear, why the boy can't have a car of his own, arise. Conflicts with parents over whom one dates are fairly frequent. Girls worry over getting dates, for dating is prestigeful behavior.

Research shows that age fourteen appears to be the pivotal year in boy-girl relations. Below this age four-fifths of American youth do not date formally. One study revealed that less than one per cent of our girls date regularly until they reach fourteen. High school entrance appears to be the cultural signal for permis-

sion and expectation to date.

In the age category 14-16 approximately half of our adolescent girls date regularly, while one-quarter of them don't date. Over sixteen, 7 out of 10 date regularly, a few are engaged or married, and approximately 5 per cent don't date. Other studies reveal that 80 per cent of high school seniors and 90 per cent of college students date. On an average, high school students date once a week.

Much has been written in recent years about adolescent "going steady." Some alarm has been voiced about this *supposed* custom and many writers have attempted to explain its existence. But objective research does not bear out the existence in any great degree of this social pattern. Apparently, only about 20 per cent of American youth "go steady," the practice being most widespread among high school seniors. Adolescent girls, in general, appear to be quite critical of the idea of "going steady." And, interestingly, this negative feeling is most prevalent among those in the upper years of high school where three-fifths view the practice negatively.

Though they may *not* go steady, the typical teen-ager wants to *be* with the opposite sex. They report this need themselves in a recent study. Their interest-activities, as they itemized them, include going to the movies twice a month; watching television two hours a day—(their program preferences being thrillers, westerns, and comedy;) listening to radio one hour daily; just plain talking; and dancing, especially dancing. Some 89 per cent of the girls and 75 per cent of the boys love to dance. In all these activities, not only dancing, they want the company of the opposite sex; they want dates.

The standard of morality on dates, the American girl feels to be her responsibility. Considering the lack of concensus in our society as to what constitutes permissible heterosexual behavior, we should expect a wide variance in adolescent sexual practices. Students of the subject find this to be true. They find also, however, that adolescent sexual codes tend to be more conservative than are those of their elders. The norms appear to be what has been termed a "petting-with-affection" code for girls, and the double standard for boys. Another code, among older adolescents, where the affectionate relationship has been stabilized for a period of time, permits coitus.

A recent study of nearly 600 college students revealed 1 per cent of the girls not dating; 3 per cent, when dating, would not go beyond holding hands; 46 per cent permitted kissing and hugging, but not more; 40 per cent allowed heaving petting; 10 per cent permitted intercourse. For the boys in the study, 37 per cent proceeded as far as intercourse.

Cannot Generalize

Of course, one cannot generalize to all adolescents from the above findings. For one thing, there was a social class bias in the research—its subjects being college students largely of middle class background. Kinsey suggested that lower class males are more permissive in their sexual attitudes and practices are influenced by religion, ethnic group membership, and education, in addition to social class.

On the whole it would appear that the fairly widespread belief in the sexual irresponsibility and extremism of youth is not borne out.

Among adults in our society there appears to be a general tendency to seek social recognition. Seemingly, we want to be looked up to, to be well thought of by our peers. In

short, we desire to be important.

This need for prestige is prevalent also among adolescents. In fact, activity toward gaining social status constitutes a principal form of behavior in what some refer to as the social system of the high school. Some believe that prestige and status are more important goals to the teenager than is academic learning.

In the hierarchy of activities that confer high social status, informal as well as formal organizations are very important. For example, one must be a member in good standing in the right clique. In order to remain in good standing, the youngster must abide by the rules of behavior expected of clique members: to dress as the clique dictates, meet the academic standards it sets, come from the right social class, and abide by its moral code.

The status-seeking adolescent must also participate in the school's formally sponsored extra-curricular activities. The "knowing" teen-ager, however, becomes aware of those activities that will promote his cause and participates only in the most prestige-laden. Of the more than fifty different non-academic pursuits that may be found in the average high school, among boys the activity conferring the greatest prestige is athletics, especially basketball and football. Cheerleading places highest among girls.

This high valuation placed on sports because of their status implications is emphasized in a recent report concerning our high schools: The author's conclusions are summed up as follows: "Research—based on the visibility of athletic stars, on most desired achievement, on the composition of the leading crowd, on status criteria in leading-crowd membership, on popularity — demonstrates conclusively that athletics is far and away more important as a value among high school students than intellectual achievement."

We must not jump to the conclusion, however, that the desire for academic achievement is entirely lacking. It is present—but for most students good grades are but another means to high social status which the poor student cannot achieve.

Perhaps this is one of the reasons that cheating is so prevalent in our schools. In a recent nationwide study adolescents reported widespread cheating in both high school and college. Ironically, these same young people stated that their school work is *too easy*. In fact, 88 per cent said they could do more work and 45 per cent reported they could do *much more*. Apparently they would like to be forced to take more history, philosophy, languages, math, and science.

One wonders about genuiness of such statements, however. Would a more complete and difficult curriculum motivate academic achievement as a goal in itself? Or simply provide additional subjects and teachers to be manipulated on the road to status? Some investigators maintain that the "wise" teener, actively seeking high social position, quickly learns "how to get the grade," "what the teacher expects." It might be well for the educational administrator to check academic motivations before instituting too many innovations. In another large-scale study of adolescents, nearly 55 per cent expressed the wish that they could be more *interested* in their studies.

Moreover, before changing the present academic system, we might well see what can be done about maintaining the student population in school. For a society that looks to education as a principal means of national security and vertical social mobility, we permit a very *high*

school dropout rate. Of the 120,000 firstgraders entering North Carolina public schools this year, it is estimated that less than half will complete high school. In 1950, to be more specific, 109,983 children began their education in our state. In June, 1962, last month, only 44 per cent of this number graduated. The rest dwindled through dropout.

There is a good deal of evidence that one's educational chances are closely linked with the socio-economic status of one's parents. Adolescents coming from lower-class homes have tremendous obstacles to overcome. They appear to be highly disadvantaged not only in achieving rank in the school prestige system, and participating rewardingly in school social activities, but actually in remaining in school at all.

The school dropout would appear to present a particularized problem for those interested in alcohol education. How do you reach him extramurally?

There is an anomaly in the widespread cheating in school reported by adolescents and the large number of youth who profess a sincere belief in *religion*. Yet a number of studies in the last several years has underscored the religious acceptance of American youth. This research has shown that anywhere from two-thirds to three-fourths of our teenagers respond that they have firm religious beliefs.

The most recent of these studies found that 76 per cent of its large sample believe God to be a judge of our every action, who is constantly observing us in order to reward or punish us. An even larger percentage have a firm belief in the "hereafter." About two-thirds of the high school and working respondents indicated that they believe the Bible to be completely and wholly true, while nearly a quarter of the college youth indicated a similar acceptance.

That some of our teen-agers are devoutly religious and religion plays an important role in ordering their lives in undoubtedly true. That it is significant in the large number indicated may be questionable.

As we all know, religion is *very popular* in America today. Church membership and church attendance are higher than ever before in our history. Religious profession and behavior are *socially acceptable behaviors*. Yet many religious leaders and other students are skeptical of this heightened religious activity.

Their concern was borne out in a recent nationwide study which revealed that over fifty per cent of our population could not name even one of the first four gospels. Likewise, not long ago, when thirty outstanding citizens of our country were asked to rate the one hundred most important events in all history, the birth and crucifixion of Christ tied for fourteenth place with the Wright brothers first flight, and the discovery of the X-ray.

Studies of the religiosity of college students reveal a marked difference between *professed* belief and *actual* belief. One wonders if many teenagers are simply *for* religion, without actually being very religious?

While our youth unhesitatingly endorse religion, even more strongly they *want no part of politics*. The average teen-ager sees political activity as a dirty game, run by unscrupulous, selfish insiders. He wants no part of it. In fact, despite the attention that has been given to reducing the voting age to 18, only about a third of our youth is interested in attaining the vote at this age.

Nor is American youth interested in social reform *coming through his participation*. He'll reform himself,

he tells us, he'll help improve the world through *self-improvement.* Let others attempt to bring about the needed modifications in *world society.* Along this line, one recent poll showed that about 40 per cent of our adolescents are interested in the Peace Corps, but they would like to work in Western Europe, not in the underdeveloped areas of Africa, Asia, or Latin America, where life may be somewhat more primitive.

On the other hand, our young people are *not* the out and out *political conservatives* they have been tagged in recent years. The most prominent and ultra-conservative with presidential hopes attracts only a small fraction of our youth. At the same time, they seem ill-prepared to function effectively in a political democracy when their time comes: studies reveal that they have very little knowledge of world affairs, know practically nothing about communism, even know very little about our economic system. In all these deficiencies, however, they are simply a youthful reflection of the larger American culture.

Life Expectations

What do our teen-agers expect out of life? From their responses, their goals are much more limited than you would think. Principally, they want "happiness." This they believe to be comprised of marriage, family and home. Very, very few are interested in becoming *famous;* only a fraction desire to be of service to humanity. Occupationally, they want no part of the ministry, mission work, or social work. While they expect to work *harder* for their goals than their parents, they want to work for someone else, in particular, large corporations, not themselves. *Business employment* appears to be the number one choice for boys. Girls, despite the modern trend toward work outside the home, plan on being housewives.

To achieve their life and work goals, the adolescent sees a college education as imperative. In order to achieve the just-a-little-bigger-than-average salary he expects to earn as an adult, he is willing to work his way through college if he has to. This would seem to indicate earnestness and seriousness in teen-agers.

Yet, overall, some observers believe that the dominant note today in American teen-agers' behavior is *having fun.* Sports, play, and social activity appear to be their primary interests. They have become a tremendous commercial market for clothes, records, cosmetics, and the movies. They have their own magazines. They swim, they skate, they waterski, they dance. They're on the move—playing and having fun.

To some, this may seem to be irresponsible behavior. To others, perhaps, more astute observers of American culture, our adolescents may be pointing the way to the future. Given the direction that cultural change is taking in our society, especially the headlong rush of automation, perhaps our youth are emphasizing the *right* values when they tend to organize their lives around play and social activity. It is possible as industrialization and automation change the nature and quantity of work needed in our economic system, that adult behavior will become organized around leisure-time activities instead of around work activity as it is now. In this sense, adolescent fun values may be *adult values* of the future. Maybe we'd better start learning from our young.

But a final question might be: what does a heightened and continued emphasis on fun value portend for alcohol use and alcohol education?

DIRECTORY OF OUTPATIENT FACILITIES

for

ALCOHOLICS AND/OR THEIR FAMILIES

Competent Help Is Available At The Local Level

Key to Facility and its Service

***Local Alcoholism Programs**

for
(Alcoholics and Their Families)

—Education
—Information
—Referral

†Mental Health Facilities

for
(Alcoholics and Their Families)

—Outpatient Treatment Services

‡Aftercare or Outpatient Clinics

for
(Alcoholics who have been patients of the N. C. Mental Hospital System)

—Outpatient Treatment Services

ASHEVILLE—

**Educational Division, Board of Alcohol Control;* Parkway Office Building; Phone ALpine 3-7567.

†*Mental Health Center of Western North Carolina, Inc.;* 415 City Hall; Phone: ALpine 4-2311.

BURLINGTON—

**Alamance County Council on Alcoholism;* Margaret Brothers, Executive Director; Room 802, N. C. National Bank Building; Phone: 228-7053.

‡*Outpatient Clinic;* Alamance County Hospital; Hours: Wed., 9:00 a.m.-4:00 p.m.

BUTNER—

‡*Aftercare Clinic;* John Umstead Hospital; Hours: Mon. Fri., 9:00 a.m.-4:00 p.m.

CHAPEL HILL—

†*Alcoholism Clinic of the Psychiatric Outpatient Service;* N. C. Memorial Hospital; Phone: 942-4131, Ext. 336.

**Orange County Council on Alcoholism;* Dr. D. D. Carroll, Director; 102 Laurel Hill Rd.

CHARLOTTE—

**Charlotte Council on Alcoholism;* Rev. Joseph Kellermann, Director; 1125 E. Morehead St.; Phone: FRanklin 5-5521.

‡*Mecklenburg Aftercare Clinic;* 1200 Blythe Blvd.; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Mental Health Center of Charlotte and Mecklenburg County, Inc.;* 1200 Blythe Blvd.; Phone: FRanklin 5-8861.

CONCORD—

†*Cabarrus County Health Department;* Phone: STate 2-4121.

DURHAM—

‡*Aftercare Clinic;* Watts Hospital; Hours: Tues. and Fri., 2:00-5:00 p.m.

**Durham Council on Alcoholism;* Mrs. Olga Davis, Executive Director; 602 Snow Bldg.; Phone: 682-5227.

FAYETTEVILLE—

†*Cumberland County Guidance Center;* Cape Fear Valley Hospital; Phone: HUdson 4-8123.

GASTONIA—

†*Gaston County Health Department;* Phone: UNiversity 4-4331.

GOLDSBORO—

‡*Outpatient Clinic;* Cherry Hospital; Hours: Tues. and Fri., 10:00 a.m.-12:00 noon. Thurs., 2:00-4:00 p.m.

**Wayne Council on Alcoholism;* A. T. Griffin, Jr., Executive Director; P. O. Box 1320; Phone: 734-0541.

GREENSBORO—

**Greensboro Council on Alcoholism;* Worth Williams, Executive Director; 216 W. Market St., Room 206 Irvin Arcade; Phone 275-6471.

†*Guilford County Mental Health Center;* 300 E. Northwood St.; Phone: BRoadway 3-9426.

†*Family Service Agency;* 1301 N. Elm St.

‡*Outpatient Clinic;* 300 E. Northwood St.; Hours: Mon. and Thurs., 5:00-10:00 p.m.

GREENVILLE—

†*Pitt County Mental Health Clinic;* Pitt County Health Department, P. O. Box 584; Phone: PLaza 2-7151.

HENDERSON—

**Vance County Program on Alcoholism;* Dr. J. N. Needham, Director; 2035 Raleigh Rd.; Phone: GEneva 8-4702.

HIGH POINT—

†*Guilford County Mental Health Center;* 936 Mountlieu Ave.; Phone 888-9929.

JAMESTOWN—

**Alcohol Education Center;* Ben Garner, Director; P. O. Box 348; Phone: 883-2794.

LAURINBURG—

**Scotland County Citizens Committee on Alcoholism;* M. L. Walters, Executive Secretary; 308 State Bank Bldg.; Phone: 276-2209.

MORGANTON—

‡*Aftercare Clinic;* Broughton Hospital; Hours: Mon.-Fri., 2:00-4:00 p.m.

NEW BERN—

**Craven County Council on Alcoholism;* Gray Wheeler, Executive Secretary; 411 Craven St., P. O. Box 1466; Phone: 637-5719.

*†*Psychiatric Social Service,* Craven County Hospital; Phone: 638-5173, Ext. 294; Hours: Mon.-Fri., 9:00 am.-5:00 p.m.

NEWTON—

**Educational Division, Catawba County ABC Board;* Rev. R. P. Sieving, Director; 130 Pinehurst Lane; Phone: INgersoll 4-3400.

RALEIGH—

‡*Aftercare Clinic;* Dorothea Dix Hospital, S. Boylan Ave.; Phone: TEmple 2-7581; Hours: Mon.-Fri., 1:00-4:00 p.m.

†*Outpatient Clinic of the Mental Health Center of Raleigh and Wake County, Inc.;* Wake Memorial Hospital; Phone 834-6484; Hours: Mon.-Fri.; 8:30 a.m.-5:30 p.m.

SALISBURY—

**Educational Division, Rowan County ABC Board;* Peter Cooper, Director; P. O. Box 114; Phone: 633-1641.

†*Rowan County Mental Health Clinic;* Community Bldg., Main and Council Sts.; Phone: MElrose 3-3616.

SANFORD—

†*Mental Health Clinic of Sanford and Lee County, Inc.;* 106 W. Main St. P. O. Box 2428; Phone: 775-4129 or 755-4130.

SHELBY—

†*Cleveland County Mental Health Clinic;* 101 Brookhill Rd.; Phone: 482-3801.

SOUTHERN PINES—

**Moore County Alcoholic Education Committee;* Rev. Martin Caldwell, Director; P. O. Box 1098; Phone: OXford 2-3171.

†*Moore County Mental Health Clinic, Inc.;* Box 1098; Phone 695-7781.

WADESBORO—

**Educational Division, Board of Alcohol Control;* Robert M. Kendall, Director; 125 W. Wade St.; P. O. Box 29; Phone: 694-2711.

WILMINGTON—

†*Mental Health Center of Wilmington and New Hanover County;* 1013 Rankin St.; Phone: ROger 2-8294.

**New Hanover County Council on Alcoholism;* Mrs. Margaret Davis, Executive Secretary; 211 N. Second St.; Phone: 736-7732.

WILSON—

‡*Aftercare Clinic;* Encas Station; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Wilson County Mental Health Clinic;* Encas Rural Station; Phone: 237-2239.

WINSTON-SALEM—

*†*Alcoholism Program of Forsyth County;* Marshall C. Abee, Executive Director; 802 O'Hanlon Bldg., 105 W. 4th St.; Phone: PArk 5-5359.

YADKINVILLE—

**Alcoholism Information Center;* Rev. James A. Haliburton, Director; Yadkin County Courthouse.

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The following books are available from the North Carolina State Library through local libraries to residents of North Carolina. To obtain any of the following books, go to your community library and make the request. Save this list for future reference.

ALCOHOL—PHYSIOLOGICAL EFFECT

The Commonsense Book of Drinking, *Leon Davis Adams.*

Alcohol, Its Effects on Man, *Haven Emerson.*

Alcohol and Youth, *Emma Holloway.*

Social Drinking, *Giorgio Lolli.*

Alcohol and Caffeine, *Harvey Nash.*

ALCOHOLICS

Understanding Alcoholism. Edited by *Seldon D. Bacon.*

Just One More, *James Lamb Free.*

Here's to Sobriety, *Thomas Fullam.*

The Life of an Alcoholic, *Harry Daily Proctor.*

A Sober Faith, *George Aiken Taylor.*

ALCOHOLICS—PERSONAL NARRATIVES

Prodigal Shepherd, *Ralph Pfau.*

ALCOHOLICS ANONYMOUS

Alcoholics Anonymous, *Alcoholics Anonymous Publishing, Inc.*

Alcoholics Anonymous Comes of Age, *Bill W.*

Twelve Steps and Twelve Traditions, *Alcoholics Anonymous Publishing, Inc.*

Recovery From Alcoholism, *Karl Edward Voldeng.*

The Road Back, *Joseph Kessel.*

ALCOHOLISM

The Other Side of the Bottle, *Dwight Anderson with Page Cooper.*

Problems in Addiction: Alcohol and Drug Addiction, *William C. Bier.*

Alcoholism and Society, *Morris E. Chafetz and Harold W. Demone, Jr.*

Drunks Are Square Pegs, *Charles Clapp.*

Understanding and Counseling the Alcoholic Through Religion and Psychology, *Howard John Clinebell.*

Drinking and What to Do About It, *William A. DeWitt.*

How to Help an Alcoholic, *Clifford J. Earle.*

Alcoholism, its Scope, Cause, and Treatment, *Ruth Fox and Peter Lyon.*

The Problem Drinker, *Joseph Hirsh.*

The Disease Concept of Alcoholism, *Elvin Morton Jellinek.*

Origins of Alcoholism, *William McCord and Joan Gudeman.*

New Primer on Alcoholism, *Marty Mann.*

Asylum, *William Buehler Seabrook.*

The Cup of Fury, *Upton Beall Sinclair.*

To Know the Difference, *Albert Ullman.*

Hospital Treatment of Alcoholism, *Robert S. Wallerstein in collaboration with John Chotlos and others.*

Tomorrow Will Be Sober, *Lincoln Williams.*

Alcohol, Science, and Society, *Center of Alcohol Studies, Yale University.*

ALCOHOLISM—BIBLIOGRAPHY

Alcoholic Education for the Layman, (a bibliography, selected and annotated), *Margaret E. Monroe and Jean Stewart.*

ALCOHOLISM—FICTION

The Late Liz, *Elizabeth Burns.*

The Lost Weekend, *Charles R. Jackson.*

TEMPERANCE—STUDY AND TEACHING

Young People and Drinking, *Arthur H. Cain.*

Teen-agers and Alcohol (a handbook for the educator), *Raymond G. McCarthy.*

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.